THE UNIVERSITY
OF BIRMINGHAM

Health Services Management Centre
School of Public Policy

Opportunity or threat? Cash-limited prescribing budgets in primary care groups

Darrin Baines and Judith Smith

Speakers

Judith Smith,	Fellow, HSMC, University of Birmingham
Darrin Baines,	Senior Lecturer, Health Economics Facility, HSMC
Stephen Earwicker,	GP and Secretary, Nottingham LMC
Charles Alessi,	Kingston & Richmond Multifund
Sandra Briant,	Pharmaceutical Advisor, Doncaster Health Authority
June Crown,	Director, South East Institute for Public Health
Kevin Guinness,	Head of Pharmacy and Prescribing, NHS Executive

Introduction

To help support Primary Care Groups (PCGs) in the management of the prescribing element of their unified budgets, HSMC and the Health Economics Facility within HSMC are running a series of seminars on prescribing and PCGs. This briefing note summarises the findings of the first seminar in the series held on 28 January 1999 at the Health Services Management Centre. Details of further seminars in the series and copies of the briefing notes from later seminars may be obtained by completing the coupon printed on page 3.

Learning from the pioneer PCGs, Judith Smith

During her presentation, Judith examined some of the early evidence emerging from the national evaluation of GP Commissioning Pilots (primary care groups), which is being undertaken by Judith and colleagues at the HSMC. Judith explained that, in 1997, the Labour government announced that 40 GP Commissioning Group pilot sites were to go live in April 1998, each holding a cash-limited prescribing budget as a group.

Using data from the national evaluation, Judith reported that a range of techniques had been employed by pilots to help control their expenditure on drugs, improve the quality of prescribing and to allocate practice-level pharmaceutical budgets. For example, some pilots had established a specific management group to oversee prescribing and developed local incentives schemes. All but three pilots had commissioned specific professional prescribing advice, mainly from their local health authority or pilot-employed advisors. In the main, advisors usually:

(i) analysed and presented practice prescribing data,

(ii) visited local practices and

(iii) supported and facilitated improvements in practice prescribing.

An important aspect of many pilots' approach was the open sharing of prescribing data and many had reported the importance of developing a culture of trust as a prerequisite to this process of peer review.

Summarising the early findings of the national evaluation in relation to prescribers, Judith reported that the main message from the pilots was that managing prescribing was being viewed primarily as being about *quality* rather than cost, and that this was often achieved by the development of a local formulary, nested within a wider approach to quality improvements and the introduction of good practice guidelines.

In conclusion, the national evaluation had revealed that:

(i) all pilots held a prescribing budget as a group;

(ii) prescribing was a dominant issue for most sites;

(iii) many sites predicted savings against their prescribing budgets;

(iv) many pilots saw their work as prefiguring PCG implementation;

(v) the management of prescribing in the pilots in many ways prefigures the operation of clinical governance in primary care.

Prescribing budgets in the New NHS, Darrin Baines

Developing the theme of prescribing in the *New NHS*, Darrin discussed the setting and managing of practice-level prescribing budgets. Given the current proposed arrangements, he argued that the key challenges to PCGs would be:

(i) the management of a unified budget,

(ii) controlling the entry of new products,

(iii) generating savings on drug expenditure,

(iv) improving the rationality of prescribing, and

(v) possibly, the rationing of pharmaceuticals.

Although he acknowledged that prescribing budgets were likely to be an important means by which PCGs would attempt to control local prescribing costs, Darrin argued that they should *not* be set in isolation from an individual practice's prescribing plans. For example, he argued that budgets should be set after a practice had planned its prescribing savings for the next financial year, rather than relying on the budget *itself* to promote such savings.

As part of his emphasis on negotiated prescribing budgets, Darrin argued that PCGs should provide support and guidance to individual practices on how their pharmaceutical costs could be controlled. In particular, he argued that the following initiatives and changes could affect a practice's ability to manage its budget:

This publication is sponsored with an educational grant from Pfizer Limited

(i) involvement of a pharmacist in medication review and management;

(ii) involvement of nurses in prescribing;

(iii) Primary Care Act (PMS) Pilot status;

(iv) introduction of the measures outlined in the second Crown Report;

(v) changes to the Pharmaceutical Price Regulation Scheme.

In conclusion, Darrin argued that PCGs should use multiple strategies in their attempts to manage local prescribing. However, he suggested that:

(i) the ability of PCGs to control drug expenditures may be limited by the local savings available;

(ii) the fundholding scheme may have created a cost-backlog;

(iii) PCGs may face the challenge of controlling expenditure on high cost, new drugs;

(iv) in the longer term, the rationing of prescribed drugs may neither be possible nor desirable.

Learning from GP Commissioning, Stephen Earwicker

Stephen began his presentation by stating that, in order to successfully control local drug expenditures, PCGs will need to develop a prescribing strategy and to respond to the drivers of GP prescribing patterns and behaviour. He argued that there are three main influences on prescribing behaviour:

(i) patient demands,

(ii) GP knowledge, and

(iii) external influences such as secondary care prescribing and the activities of pharmaceutical advisors.

During his presentation, Stephen suggested that the Nottingham GP Commissioning Pilot had revealed some important lessons for PCGs. Stephen reported that the Nottingham Total Commissioning Project involved 288 of the 320 GPs and 108 of 117 practices in Nottingham. The project accepted a district-wide, cash-limited budget for prescribing, with each practice being allocated an indicative budget. The total budget available to project was £44.6 million, which was 8% below the regional average. In order to help manage its budget, the pilot initiated a local prescribing incentive scheme and allocated £1.1 million to the following virement projects:

(i) four-layered bandaging for leg ulcers,

(ii) HP testing available to GPs,

(iii) pharmacist-led headlice treatment,

(iv) EPO and other renal drugs, and

(v) 14 day discharge medication.

Stephen reported that some of the initiatives were harder to establish than others, so budget allocations for these had not been spent yet.

The pilot's district-wide prescribing incentive scheme allowed a 2% overspend on the total commissioning prescribing budget, with incentive payments based upon the cost, as well as the quality, of prescribing. Stephen reported that, at first, there were concerns that practices would not respond to a district-wide scheme. However, initial data suggested that the scheme is working.

Stephen also reported that the pilot established a prescribing advisory committee, and employed four part-time pharmaceutical advisors who undertook practice visits, interpreted local PACT reports, helped develop practice - and Nottingham - wide formularies and produced a publication entitled *The Nottingham Prescriber*. The pilot also established speciality forums for: (i) gastroenterolgy, (ii) ophthalmology, (iii) ENT, (iv) urology, and (v) orthopaedics.

Although data were only available for April to September 1998, Stephen reported that the pilot predicted an overspend of approximately 1 per cent, (although a 2% overspend was allowed) and that, at the end of the financial year, a surplus of around 0.5 per cent was expected. Stephen reported that the pilot believed that its success was due to:

(i) the common ownership of the prescribing budget;

(ii) regular feedback to practices;

(iii) the joint approach taken with trusts;

(iv) good pharmaceutical advice;

(v) the use of an incentive scheme;

(vi) a focus on the middle ground.

In conclusion, Stephen predicted that the move towards primary care trusts may lead to:

(i) the development of local formularies;

(ii) extensive guideline/protocol usage;

(iii) direct negotiations with suppliers;

(iv) the end of the FP10;

(v) change in the role of the high street pharmacists;

(vi) introduction of disease management consortia.

Managing prescribing in a multifund, Charles Alessi

Charles opened his presentation by giving a background to the Kingston and Richmond Multifund's experiences of managing prescribing amongst local practices. The multifund was the first in the country and was located in London within a small health authority, which previously had a significant overspend. There are currently two acute trusts and many community pharmacists working in the area. During the early days, Charles reported that the main drivers of change in the multifund were: (i) a focus on costs, which led to a focus on quality, and (ii) local GPs being angry at cost-shifting from local hospitals.

At the time that the multifund was established, a new drugs and therapeutic committee (D&TC) was introduced and the trust drugs and therapeutic committee became empowered. Charles argued that the time spent with the trust D&TC enabled the multifund to achieve its aims for prescribing. Although the multifund made much progress in improving local prescribing, the barriers to its success included:

(i) in primary care, lack of consistency in GP prescribing and the absence of adequate information technology support;

(ii) in secondary care, trusts often thinking about their own interests rather than those of the patient;

(iii) finally, the local health authority was not always happy to relinquish control.

In order to help improve local prescribing, the multifund appointed a prescribing advisor, who spent much time developing complementary messages and working closely with the local health authority. The advisor was also involved in developing multifund and D&TC linkages, producing annual prescribing reports and undertaking practice visits, targeting certain therapeutic areas and developing quality indicators. Charles stated that an important contribution to the multifund's success was that local GPs saw the prescribing adviser as working for *them* rather than the local health authority. However, one limitation of the multifund's approach was that local prescribing reports were initially anonymised, which had recently changed. As a result, prescribers were able to compare themselves with their peers. Other limitations included: (i) no incentives other than fundholding savings, and (ii) the multifund needed more than one prescribing advisor.

According to Charles, the lessons for PCGs from the multifund include:

(i) PCGs will need strategies for managed entry of new drugs;

(ii) shifting some prescribing back into secondary care is likely to be an important issue;

(iii) the establishment of dressings projects and nurse prescribing will be important;

(iv) community trust involvement is likely to be vital;

(v) new roles for practice pharmacists will develop;

(vi) there is a need to encourage different agencies to work together;

(vii) real comparability requires naming of prescribers, which cannot be achieved with anonymous data;

(viii) clinical governance and audit is the way forward;

(ix) performance indicators will be important, as will incentive schemes;

(x) integrated care and whole systems thinking is the way ahead;

(xi) we cannot alter the behaviour of prescribers who refuse to change.

The role of practice pharmacists, Sandra Briant

Sandra presented the experience of the Doncaster Prescriber Support Project, which employed practice pharmacists to help support local GPs in their efforts to manage prescribing. The scheme was established under the ethos of re-investing savings, with the slogan 'spending a dollar to save two'. The aim of the project was to bring drug expenditure in Doncaster to within acceptable financial limits, whilst maximising the health gain to local people from available resources. The scheme also attempted to:

(i) establish ongoing independent, practice-based prescriber support,

(ii) develop the role of the pharmacist in primary care,

(iii) raise standards of pharmaceutical care within general practice.

In September 1995, Doncaster Health Authority became aware that further action would need to be taken in order to address escalating prescribing costs in the area. As a result, the Doncaster Prescriber Support Project was established. In the first phase of the support project, 6 practice pharmacists (5.7 wte.) were employed to support 8 practices and the local total purchasing pilot of 9 practices. All participating practices were voluntary and pharmacists were initially given a one year contract. As the pilot was a new innovation, a significant amount of time was spent in training pharmacists and developing the project. The project commissioned the University of Nottingham to evaluate the scheme.

During the first phase, the health authority made up to £200,000 available for the pilot. The savings made by the participating fundholding practices (up to the cost of the pharmacists) were returned to the health authority and were re-invested in phase two of the scheme. A top slice of the 1996/97 drugs budget of £50,000 was used to pay for non-fundholding involvement. However, the pilot also had a number of hidden costs, including:

(i) advisor time,

(ii) health authority and practice staff time,

(iii) the opportunity costs of using the resources on the initiative and not elsewhere.

During the pilot, a group of lead partners from participating practices reviewed the employment contracts for pharmacists, developed job descriptions, attended recruitment interviews, attended monthly meetings (later with pharmacists) and attended forums for sharing ideas. The second phase of the scheme operated from September 1997 onwards and involved 12 pharmacists (8.5 wte.), supporting 19 practices and the local total purchasing pilot, covering approximately 60 per cent of Doncaster's population. During the pilot, all pharmacists were moved to permanent contracts.

Some of the findings from phase one are:

(i) practices seem to sometimes improve prescribing before entry into scheme, perhaps as they put their 'house into order';

(ii) generic prescribing has increased;

(iii) prescribing of drugs of limited therapeutic value decreased;

(iv) prescribing of less modified/sustained release preparations reduced;

(v) prescribing of newer agents was not affected;

(vi) quality improved or, at least, was maintained;

(vii) a reduction in budget overspending was achieved.

In conclusion, Sandra argued that in the future pharmacists could fulfil the following roles and functions:

(i) provide clinical pharmacy to GPs;

(ii) help control practice spending on drugs;

(iii) promote better practice;

(iv) improve pharmaceutical care;

(v) provide disease management;

(vi) provide integration with community pharmacists.

Extending the authority to prescribe, June Crown

June opened her presentation by discussing the progress of the Review of the Prescribing, Supply and Administration of Medicines. She said that the second report was to be published soon. However, she pointed out that the report was not likely to have an immediate effect, as it would take time for public discussion, any resulting legislation and piloting to occur. If the report's recommendations were accepted, the Review Team anticipates three strands of activity:

(i) primary legislation to change the Medicines Act and NHS Act;

(ii) training programmes for new prescribers;

(iii) administrative changes, mainly concerned with the arrangement for registration and for payment from public funds through the NHS.

During its work, the review team divided the project into the following areas, based around patient care groups:

(i) 'healthy' patients requiring preventive services or with self-limiting conditions;

(ii) patients with chronic/progressive illnesses living in the community;

(iii) patients with serious conditions requiring rapid response;

(iv) patients with mental health/behavioural problems.

In order to guide its progress, the terms of reference instructed the review team to bear in mind the overriding need to ensure patient safety, the effective use of resources, the skills and competencies of the various health professions, and recent changes in clinical practice and public expectations when producing its recommendations.

If you would like to be sent further details of HSMC seminars on prescribing and PCGs,

contact: ***Darrin Baines*** tel. 0121 414 7705. Email: bainesdl@hsmc.bham.ac.uk

or ***Judith Smith*** tel. 0121 414 7073. Email: smithjaz@bham.ac.uk or complete this form and return to the address overleaf.

Name: _____

Address: _____

_____

_____

Telephone: _____ Fax: _____ Email: _____

As part of its remit, the group was expected to develop a consistent policy framework to guide its judgements on the circumstances in which health professionals inside and outside the NHS might undertake new responsibilities with regard to the prescribing, supply and administration of medicines. The review team was required to examine the possibility of extending the authority to prescribe across all health care professional groups and in all settings, not just within the NHS. As part of its remit, the team was also asked to advise on the likely impact of any proposed changes on clinical outcomes, the convenience of health service users, professional relationships and costs.

During its work, one of the difficulties encountered by the review team was the lack of evidence about prescribing by non-doctors, from which conclusions about the effects of changes in the UK could be drawn. The review team assumed that NHS patients are, in the main, getting the medicines that they need and that more timely interventions may lead to better outcomes and cost control. However, the team believed that better use of professional skills could be achieved by (i) extending the authority to prescribe, which would improve access to medications, and (ii) removing the artificial divide between prescribing and clinical responsibility that exists in some clinical situations at present. These changes should improve the quality of care offered to patients. However, any changes will inevitably incur costs in training and organisation, some of which would be expected to fall on the professionals rather than the NHS. As part of its study, the review team was also asked to consider the possible implications for legislation and for professional training and standards.

In conclusion, June suggested that the messages were that extending the authority to prescribe will:

(i) not be a way of compensating for the present shortage of doctors;

(ii) present opportunities for professionally appropriate work;

(iii) if appropriately managed, improve quality and cost control.

Finally, she stated that any proposals to extend the authority to prescribe must be seen within a quality agenda, especially with the introduction of NICE and an increased emphasis on audit and clinical governance.

NHS Executive view of prescribing budgets, Kevin Guinness

Kevin started his presentation by stating that PCG prescribing budgets will not be cash-limited, indeed, whilst they will be within a cash-limited unified budget and there will be no particular limit on how much should be spent on drugs. As a result, PCGs will have to decide what percentage of their total allocations should be spent on pharmaceutical products. As a result of the fundholding and total purchasing schemes, Kevin stated that PCGs will not be going into the unknown. However, the essential change is that prescribing budgets will apply to all practices and all prescribing (including nurse prescribing). Kevin stated that there will be room for local discretion and that the clinical freedom to prescribe will be maintained. Nevertheless, there will also be a gradual move towards greater use of national guidelines for prescribing, particularly as NICE will issue guidelines for GPs to follow.

Kevin set out, the Government's main policy objectives in this area as follows:

(i) ensuring that patient needs are met,

(ii) further developing cost-effective and clinically effective prescribing, and

(iii) encouraging the consideration of prescribing in a wider context.

As a result of the emphasis on promoting economic and effective prescribing, better use will be made of NHS resources. The introduction of unified budgets will also encourage PCGs and GPs to look at spending on drugs alongside expenditure on all other services.

Although PCG budgets will be cash-limited, financial risk should not be a major worry, as the NHS has had long experience of managing such risks. There will however, have to be greater consideration of how priorities will be set, and some trade-off between local priorities may be necessary. Kevin argued that PCG prescribing budgets will:

(i) lead to better use of resources and better patient care;

(ii) address some of the limitations of current systems (for example, cost-shifting of hospital expenditure into general practice);

(iii) encourage people to think about what they spend and whether to prescribe or not;

(iv) promote prescribing based on need.

To help GPs manage their budgets, the NHS Executive plans to promote improvements in prescribing advice, subject to manpower and resource implications. The Executive has also put arrangements in place to scan the horizon for all new technologies and procedures, not just drugs. A new technology will be referred to NICE if it is likely to lead to a high level of expenditure, or where there are other factors which might lead to a need for advice.

Since the date of this presentation a consultation document has been published, which sets out in detail what is proposed. NICE will appraise the evidence from manufacturers and produce clear guidance for NHS. NICE will not however, simply be there to stop certain things, but will attempt to speed up the use of effective and cost-effective interventions and to suggest whether more evaluation work is needed. The PRODIGY system will also be modified to print something that can be given to a patient that is not a prescription, which will help end some consultations.

In conclusion, Kevin looked to the future and stated that the NHS is relatively stable and that there was likely to be incremental, gradual change in the management of primary care prescribing over the next five years.

Conclusions

Summing up the findings of the day, Judith Smith suggested that the following lessons could be learnt for PCGs:

- **prescribing is likely to dominate in the early days of PCGs;**
- **a range of techniques will be used to manage prescribing;**
- **sharing information and developing peer-review will be vital;**
- **addressing 'outliers' will be a challenge for PCGs;**
- **pharmaceutical advice is key to the support of peer-review;**
- **quality, as well as costs, will be an issue for PCGs;**
- **prescribing is part of a wider drive to improve care.**

Please return to:
Darrin Baines or Judith Smith,
Health Services Management Centre,
University of Birmingham,
Park House,
40 Edgbaston Park Road,
Birmingham B15 2RT.

Telephone: 0121 414 7050
Fax: 0121 414 7051